Client Screen Identifier

Today's Date: _____/_____/__________ Assessment Scheduled: [ ] Yes [ ] No

Name: ____

Mailing Address: ____ Phone Number: (______)_________-_________

____ Social Security No: ________-______-________

City State Zip Code

Date of Birth: ____/____/_______ Gender: ___________ Age: ___________

Education: *(circle one)* 9 10 11 12 College: *(circle one)* 2 4 6 8 Ethnicity: _________________

Marital Status: *(circle one)* Single Married Separated Divorced Widowed

Intravenous User: [ ] Pregnant: [ ] Co-Occurring Disorder: [ ]

Primary Care Physician: ___________________________________ Psychiatrist: ____________________________

Funding Source(s)/Insurance:______________________________ ID#: ___________________________________

Housing Status: [ ] Unsheltered [ ] Sheltered (Program) [ ] At-Risk (Sleeping at family/friends home; not permanent)
[ ] Permanent/Stable Housing (Rent or Own)

Are you employed? [ ] Yes [ ] No If yes, where? ____

Did you serve in the military? [ ] Yes [ ] No If yes, provide date(s) of placement and rank: _______________

____

Service Coordinator/Referral Source: ____

Referring Program: [ ] HPA [ ] Drug Court [ ] Federal Probation [ ] DHS [ ] Other: __________________

Type of Service Needed: [ ] Substance Abuse Treatment [ ] Anger Management [ ] Domestic Violence
[ ] Mental Health Treatment [ ] Other: ________________________________

Have you received services from Lokahi Treatment Centers before? [ ] Yes [ ] No
*If yes, please answer additional questions below.

Admission Date: ____/____/_______ Discharge Date: ____/____/_______

Program: [ ] EIP/DUI [ ] OP [ ] LIOP [ ] IOP [ ] Anger Management [ ] Domestic Violence

Successful Completion? [ ] Yes [ ] No

In case of emergency, whom would you like us to contact?

Name: ____ Phone Number: (______)_________-__________

FOR STAFF USE ONLY

Referred To: ____

Revised 5/15
JW

Name: ______________________________ Date: ____/____/________

CAGE–AID

1. Have you ever felt you ought to cut down on your drinking or drug use?
Yes / No

2. Have people annoyed you by criticizing your drinking or drug use?
Yes / No

3. Have you felt bad or guilty about your drinking or drug use?
Yes / No

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
Yes / No

For Staff Use Only

Score: _____ / 4

Revised 5/15
JW

Name: ________________________________ **Date:** ____/____/______

Michigan Alcohol Screening Test

	ANSWER Yes / No
Do you feel that you are a normal drinker? (By "normal" we mean that you drink less than or as much as most other people)	_____
Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	_____
Do you ever feel guilty about your drinking?	_____
Do friends or relatives think you are a normal drinker?	_____
Are you able to stop drinking when you want to?	_____
Have you ever attended a meeting of Alcoholics Anonymous?	_____
Has your drinking ever created problems between you and your wife, husband, a parent, or other near relative?	_____
Have you gotten into trouble at work because of your drinking?	_____
Have you ever neglected your obligations to your family or your work for two or more days in a row because of your drinking?	_____
Have you ever gone to anyone for help about your drinking?	_____
Have you ever been in a hospital because of drinking?	_____
Have you ever been arrested for driving under the influence of alcoholic beverages?	_____
Have you ever been arrested, even for a few hours because of other drunken behavior?	_____

Name: ______________________________ Date: ____/____/________

Drug Use Questionnaire (DAST – 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements, "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

	Circle your response	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

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